STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055183	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Health Care Center	25271 Barton Rd Loma Linda, CA 92354

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and maintained in sanitary conditions when on May 4, 2026 the following was observed:1.Multiple pieces of cooking equipment had significant accumulations of grease, grime, burntˆon residue, rust, food debris, discoloration.2.Several food items were stored on the floor. These failures had the potential to facilitate the growth of harmful microorganisms (tiny living organisms too small to be seen with the naked eye, requiring a microscope for viewing), including bacteria, viruses, and fungi significantly increasing the risk for cross-contamination and development of food-borne illnesses, potentially affecting 93 medically vulnerable residents who rely on meals prepared in the facility's kitchen.Findings:1.During a concurrent observation and interview with the Director of Kitchen (DOK) on May 4, 2026, at 6:33 AM in the dishwashing area, a stack of 18 dishˆdrying racks was observed stored on a wheeled dolly under the counter. The racks exhibited heavy mineral buildup, visible grime, worn surfaces, scratches, abrasions and areas of discoloration on the exterior plastic surface. Visible soiling was seen on the interior dividers, which come into direct contact with foodˆcontact items (glasses, utensils, cups, plates etc.). The Director of Kitchen (DOK) confirmed the dish-drying racks were not clean and acknowledged the drying racks should be maintained in clean sanitary conditions.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:41 AM of the beverage service station, the coffee and hotˆwater dispensers had visible liquid residue on their exterior surfaces, and multiple stains and spills were present on the counter beneath them. The disposable liner under the hotˆwater dispenser contained dried spills and debris. The condiment organizer held mixed sweetener packets in a cluttered arrangement, with several loose packets scattered on the surrounding surface. The labels on both dispensers were worn, stained, and affixed with multiple layers of tape. The DOK confirmed the beverage station is not clean and acknowledged these conditions create a potential for crossˆcontamination and do not meet basic sanitation and cleanliness standards.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:52 AM in the kitchen, the flat-top griddle had visible layers of grease, black burnt buildup, and dark discoloration across the cooking surface and surrounding areas. During the observation, the DOK acknowledged the flat-top griddle had not been cleaned and stated it should be cleaned after each use and at the end of the day.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:54 AM in the kitchen, the 6ˆburner stove had accumulated burnt grease and food debris across multiple surfaces. The DOK confirmed the stove appeared not to have been cleaned as required. The DOK further stated that the stove should be thoroughly cleaned after each use and at the end of each day.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:55 AM in the kitchen, oven #1 had accumulations of burnt food particles, grease stains, and dark residue on the interior surfaces, including the oven floor, side panels, and racks, with additional debris and pieces of aluminum foil scattered on the oven floor. The oven had no signage indicating it was out of order. The DOK confirmed oven #1 was not clean and stated the oven had not been used for some time. DOK acknowledged the oven should be cleaned and maintained in sanitary conditions.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:56 AM in (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the kitchen, oven #2 had heavy blackened residue, accumulated grease, burnt-on food buildup, and rust along the interior walls, racks, and bottom tray. The oven lacked any signage indicating it was out of order. The DOK confirmed oven #2 was not clean and stated the oven had not been used for some time. DOK acknowledged the oven should be cleaned and maintained in sanitary conditions.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:57 AM in the kitchen, the back metal plate behind the stove had visible layers of grease stains and dark discoloration. The DOK confirmed the back metal plate was not clean and stated that the stove and its surrounding surfaces, including the back metal plate, should be cleaned after each use and at the end of the day.During a concurrent interview and record review with the Director of Kitchen (DOK) on May 6, 2026, at 11:20 AM, the document titled, Dietary Cleaning Schedule, dated April 27, 2026, to May 3, 2026, was reviewed. The document indicated, AM [NAME] Stove/Burners - to Dietary Aid . Frequency: Sunday and contained a staff initial for Sunday May 3, 2026. The document further indicated AM [NAME] Grill . Frequency: After each use, and contained staff initials for Monday April 27, 2026, Friday May 1, 2026, and Saturday May 2, 2026. The DOK stated the stove and surrounding areas are typically cleaned after each use and at the end of each day, and that according to the Dietary Cleaning Schedule, the stove, flat-top griddles, and surrounding surfaces were cleaned. The DOK further stated that food frequently spills onto the stove during cooking and that these spills should be wiped up immediately to prevent the build-up of burnt food particles and grease. The DOK was unable to provide an explanation for the significant accumulation of burnt grease, food debris, rust and discoloration observed on the 6-burner stove, the two ovens, the flat-top griddle, the back plate crate and the adjacent surfaces.During a concurrent interview and record review with the Director of Kitchen (DOK) on May 6, 2026, at 11:25 AM, the document titled, Deep Cleaning Schedule, dated April 2026, was reviewed. The document indicated, Areas to be cleaned - under stove, stove burners, oven and has staff initials under the date April 21, 2026. The DOK stated that according to the Deep Cleaning Schedule, the stove burners and the ovens were last deep cleaned on April 21, 2026.During a concurrent interview and record review on May 7, 2026, at 4:07 PM with the DOK, the facility's undated Policy and Procedure (P&P) titled Ranges and Ovens was reviewed. The P&P states, Ranges - Cleaning Procedure: 1. Open top gas range and grill. When top grids are completely cool, remove grills from the range. Immerse grills in a solution of water and grease solvent to soak. 2. Boil grates and burners in salt/soda or other grease solvent/water solution. Clean clogged burners posts with a stiff wire brush. 3. Back apron of the range and other range surfaces should be washed with a hot detergent solution following manufacturer's instructions to remove grease. Rinse and dry with a clean cloth. 4. Range drip pans must be emptied and washed on a routinely scheduled basis. 5. Grills must be cleaned after each use. Allow sufficient time for grills to cool before cleaning. Do not use caustic or acid solutions on grills as they are used will eventually cause sticking and rusting . Ovens - Cleaning Procedure: 1. Allow sufficient time for ovens to cool before cleaning. 2. Weekly, and as often as necessary, racks and shelves should be removed and cleaned in a warm detergent solution following manufacturer's instructions. 3. Use a blunt scraper or wire brush to remove encrusted material from oven surface. 4. When a commercial oven cleaner is used, allow for ample ventilation and follow label directions. 5. Clean the exterior of the oven according to manufacturer's instructions. The DOK acknowledged the facility's P&P was not followed.During a concurrent Interview and record review with the DOK on May 7, 2026, at 4:10 PM, the facility's P&P titled Sanitization, revised on October 2008, was reviewed. The P&P stated, Policy Statement - The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1. All kitchens, kitchen areas and dining areas shall be kept clean . 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, correlations, open seams, cracks and chipped areas that may affect their use or proper cleaning . 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitizing using hot water and/or chemical sanitizing solution. 11. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: a. Equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; b. Removable components will be scraped to remove food particle accumulation and washed according to manual or dishwashing procedures. The DOK acknowledged the facility's P&P was not followed.During an interview with the Director of Nursing (DON) on May 7, 2026, at 4:20 PM, the DON stated that staff should follow facility's P&P and the kitchen, and all kitchen equipment is expected to be maintained in sanitary conditions.During an interview with the Administrator (Admin) on May 7, 2026, at 4:22 PM, the Admin stated that the kitchen and all kitchen equipment are expected to be maintained in sanitary working conditions in accordance with facility's policy and procedure. The Admin acknowledged that the facility's P&Ps titled Food Receiving and Storage, Ranges and Ovens, and Sanitization were not followed when cleaning protocols for ranges, ovens, kitchen surfaces and food storage procedures were not consistently implemented as outlined in the facility's policies.Record review of the FDA Federal Food Code, dated 2022, 4-601.11 indicates, (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. in addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.2.During a concurrent observation and interview with the DOK on May 4, 2026, at 6:59 AM in the Dry Storage Room, several food items were found stored directly on the floor, including one box of Apple Juice for the Juice machine, 2 boxes of honey (200 packets in each box), 2 boxes of Gravy Beef Instant (8x16 oz cans in each box), 6 bags of hot dog buns (16 hot dog buns in each bag) in a crate and 3 bags of Tortilla Chips in another crate. The DOK confirmed that these items are stored on the floor. DOK further stated these items were delivered earlier this morning and the delivery person failed to place them on the shelves. The DOK acknowledged the items should have been stored properly off the floor upon receipt.During a concurring interview and record review on May 7, 2026, at 4:02 PM with the DOK, the facility's Policy and Procedure (P&P) titled, Food Receiving and Storage revised October 2017, was reviewed. The P&P stated, Policy Statement - Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation 1. Food services, or other designated staff, we'll maintain clean food storage areas at all times. 2. When food is delivered to the facility it will be inspected for safe transport and quality before being accepted . 6. Food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. The DOK acknowledged the facility's P&P was not followed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when a cockroach was observed by surveyors in the facility's conference room, multiple staff interviews indicated ongoing sightings of cockroaches on multiple occasions, and the facility's pest control report indicated ongoing, active cockroach activity in the facility's dining area, resident rooms, and boiler room.This failure had the potential for compromising resident health and safety by exposing residents to disease-carrying pests, contamination of food surfaces, and increased risk of infection in a vulnerable population of 98 residents.Findings: During a concurrent observation and interview on May 4, 2026, at 6:10 AM, in the facility's conference room, with Registered Nurse 1 (RN 1), a live brown bug which was approximately one and a half (1.5) inches long and resembled a cockroach was observed to be crawling on the ground underneath the conference table. RN 1 acknowledged the bug was alive and stated it looked like a cockroach.During an interview on May 6, 2026, at 8:53 AM, with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated she had worked in the facility for the last five months and within that time she had seen cockroaches on three or four different occasions. CNA 2 stated the cockroaches she saw were in the restrooms used by staff and visitors.During an interview on May 6, 2026, at 8:58 AM, with CNA 3, CNA 3 stated she had worked in the facility for 3 years and saw cockroaches in resident bathrooms on a few occasions. CNA 3 stated she couldn't recall if she told anyone and stated she would usually just kill the cockroaches.During an interview on May 7, 2026, at 12:11 PM, with Housekeeper 1 (HK 1), HK 1 stated she had worked in the facility for a total of 14 years. HK 1 stated she saw cockroaches in the facility at least once a week. HK 1 stated when she would see the cockroaches, they would be in various resident restrooms and staff restrooms and that it was restrooms in all the facility's hallways and not one particular hallway or area.During a concurrent interview and record review on May 7, 2026, at 12:15 PM, with the Administrator (ADMIN). The ADMIN Stated the facility used a company called [name of pest control company] who came out monthly to treat the facility for pest control. A report of [name of pest control company] titled, Service Report #117922, dated March 30, 2026, was reviewed and indicated, I inspected points of entry, kitchen, kitchen office, dining area, staff offices, boiler room, and restrooms. It is noted that American cockroach activity was located in the dining area, boiler room, and near the billing office restroom. Staff also is reporting American cockroach activity in rooms [ROOM NUMBERS]. These rooms are occupied at this time and unable to be treated .), the ADMIN stated he was not aware of any ongoing cockroach activity in the facility, and he had only been the administrator for the last month. The admin further stated the facility had not yet been able to treat resident rooms [ROOM NUMBERS] for cockroaches because the only way to do that is to remove the residents from the room.During a review of the facility's policy and procedure (P&P) titled, Pest Control, revised May 2008, the P&P indicated, Our facility shall maintain an effective pest control program.1. This facility maintains an on-going pest control program to ensure that the building is monitored and treated. 2. Pest control services are provided by [name of pest control company].During a review of the facility's P&P titled, Homelike Environment, dated February 2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment.2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed the facility's policy and procedure (P&P) for three of six residents (Residents 14, 30, and 73) reviewed for advance directives (a written document that tells your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself) when:1. Resident 14 was not provided advance directive information on admission.2. Resident 30's medical record had discrepant information regarding if Resident 30 had an advance directive or not. Additionally, there was no evidence the facility requested or attempted to obtain a copy of Resident 30 advance directive.3. Resident 73's POLST (Physician's Orders for Life-Sustaining Treatment - a medical order completed by a healthcare provider that communicates a patient's wishes regarding life-sustaining treatment) was incomplete and left blank for the section regarding advance directives. Additionally, there was no evidence the facility requested or attempted to obtain a copy of Resident 73's advance directive. These failures had the potential to affect Resident 14's right to make informed decisions regarding health care, including the right to formulate an advance directive and the potential for Residents 30 and 73 to receive care that was not consistent with Resident 30 and 73 wishes regarding medical treatment and decision-making.Findings: 1. A review of Resident 14's admission Record, (contains demographic and medical information), indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included, arthrogryposis multiplex congenita (a variety of conditions involving multiple joint contractures or stiffness), muscle weakness, Abnormalities of gait and mobility (involuntary, irregular walking patterns and difficulties with functional movement), and post-polio syndrome (slow, progressive muscle weakness, severe fatigue and muscle wasting). During a review of Resident 14's advanced directive acknowledgement form dated December 15, 2025, indicated Resident 14 answered No to having an existing advanced directive and indicated Yes to wanting additional information regarding advanced directive. The form contains a section labeled Refer to SSD (Social Service Department), however, the space designated to document the date and time of the referral was left blank. The form was not signed by the resident and was incomplete. During an interview on May 7, 2026, at 12:00 PM with Resident 14, Resident 14 stated Resident 14 doesn't have an advanced directive and does not recall receiving advanced directive information from the facility. During a concurrent interview and record review on May 7, 2026, at 12:16 PM with Social Service Designee (SSD), Resident 14's Electronic Medical Records (medical information about a person that is stored on a computer) were reviewed. The SSD was unable to locate a social service note or progress note for resident 14 regarding advanced directive information given to residents. SSD stated it's facilities policy for social service to inquire if residents have an advanced directive or would like information regarding an advance directive on admission. She further stated the policy was not followed. During a concurrent interview and record review on May 7, 2026, at 12:32 PM with Administrator (Admin), the facility's Policy and Procedure (P&P) titled, Advance Directives, dated December 2016 was reviewed. The P&P indicated, 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	advance directive if he or she chooses to do so . 2. Written information will include a description of the facilities policies to implement advanced directives and applicable state law .6. Prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his or her family members and/ or his or her legal representative, about the existence of a written advance directive.7. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record.8. If the resident indicates that he or she has not established an advanced directive, the facility staff will offer assistance in establishing advanced directives. The Admin stated the facility policy was not followed. 2. During a review of Resident 30's admission Record (contains medical and demographic information), the admission Record, indicated Resident 30 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (condition where the heart can't pump blood effectively), Schizoaffective disorder (mental health condition that includes psychotic symptoms like hallucinations [hearing or seeing things that are not there]), delusions (fixed false beliefs), disorganized thinking or speech, and mood disorder symptoms like depression, and anxiety disorder (mental health condition characterized by excessive, persistent, or overwhelming fear, worry, or nervousness that interferes with daily functioning). During a review of Resident 30's POLST, dated June 1, 2023, section D – Information and Signatures indicated a checkmark next to No advance directive indicating the resident did not have an advance directive. During a review of Resident 30's Advance Directive Acknowledgement dated June 1, 2023, the Advance Directive Acknowledgement form indicated Resident 30 did have an advance directive and was initialed by Resident 30. However, the section copy provided and the section copy requested were both left blank. The form was signed by facility staff signature on June 1, 2023. During a review of Resident 30's electronic health record and physical paper medical records, there was no evidence of an advance directive on file. During a concurrent interview and record review on May 7, 2026, at 3:51 PM, with the Director of Nursing (DON), Resident 30's POLST dated June 1, 2023, and Resident 30's Advance Directive Acknowledgement dated June 1, 2023, were reviewed. The DON stated both forms had discrepant information regarding if Resident 30 had an advance directive. The DON stated she did not know why there was a discrepancy and stated the nursing staff completes the POLST form and Social Service department completes the Advance Directive Acknowledgement, form which as a new process. The DON stated she was unsure if Resident 30 had an advance directive and acknowledged the facility did not have an advance directive on file for the resident. During a concurrent observation and interview on May 7, 2026, at 4:00 PM, with the DON inside Resident 30's room, Resident 30 was standing next to his bed. The DON asked if Resident 30 had an advance directive and Resident 30 stated he did have an advance directive that was created in the past and his nephew had a copy of it. The DON then requested a copy of the advance directive and Resident 30 stated he would provide a copy to the facility. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised November 2025, the P&P indicated, .Determining Existence of Advance Directive. 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, their family members and/or their legal representative, about the existence of any written advance directives.1. If (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. 3. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings. 3. A review of Resident 73's admission Record indicated Resident 73 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure, and bacteremia (presence of bacteria in the bloodstream). During a review of Resident 73's POLST, dated April 15, 2026, the POLST Section D – Information and Signatures section regarding if the resident had an advance directive, was incomplete and left blank. During a concurrent interview and record review on May 7, 2026, at 3:55 PM, with the Director of Nursing (DON), Resident 73's POLST, dated April 15, 2026, was reviewed. The DON stated the POLST form was not completed correctly and section D was supposed to be completed by a Registered Nurse (RN), but was not. The DON further stated she was unsure if Resident 73 had an advance directive or not. The DON stated Resident 73's medical record did not have an advance directive acknowledgement or a copy of an existing advance directive. During a concurrent observation and interview on May 7, 2026, at 3:56 PM, with the DON inside Resident 73's room, Resident 73 was lying in bed. The DON asked Resident 73, if she had an advance directive. Resident 73 stated she had both an advance directive and a Power of Attorney (POA – a legal document that gives one person the authority to act on behalf of another person). The DON stated the facility was not aware the resident had an advance directive and that it was missed. The DON requested a copy of the POA and advance directive from Resident 73 and the resident stated she would provide a copy as soon as possible. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, revised November 2025, the P&P indicated, .Determining Existence of Advance Directive. 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, their family members and/or their legal representative, about the existence of any written advance directives.1. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. 3. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to help maintain dignity for one of three residents (Resident 115) reviewed for urinary catheters (a thin, flexible tube inserted through the an opening which leads into the bladder allowing urine drainage into an external collection bag) when Resident 115's urinary collection bag (bag connected to a catheter by a tube and is used to collect urine) was left uncovered and urine was visible to individuals entering the resident's room and people passing in the hallway.This failure had the potential to compromise Resident 115's dignity, cause embarrassment, humiliation, and diminish the resident's psychosocial well-being.Findings:During a review of Resident 115's admission Record, (contains medical and demographic information), the admission Record, indicated Resident 115 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (an infection usually caused by bacteria entering the urinary tract), dementia (general term used to describe a decline in memory, thinking, reasoning, and other cognitive abilities severe enough to interfere with a person's daily life and functioning), muscle weakness, and difficulty in walking.During an observation on May 4, 2026, at 12:33 PM, while in the hallway, Resident 115's room door was open, Resident 115 was lying in bed and the resident's urinary collection bag was attached to the side of his bed, was left uncovered, and 150 milliliters (ml - unit of measure) of yellow urine could easily be seen from anyone entering the room, or passing in the hallway.During a concurrent observation and interview on May 4, 2026, at 12:36 PM, with Certified Nursing Assistant 4 (CNA 4), while in the hallway, CNA 4 acknowledged Resident 115's urinary collection bag was not covered and the urine inside the bag could be seen from the hallway. CNA 4 stated all urine collection bags were supposed to have a dignity cover placed over them so you could not see the contents of the bag.During an interview on May 6, 2026, at 2:36 PM, with the facility's Infection Preventionist (IP), the IP stated urinary catheter drainage bags were supposed to have a privacy bag applied to it so you could not see the urine inside the bag. The IP further stated it was important to ensure the urine was covered so nobody could see the urine in order to maintain the residents' dignity.During an interview on May 7, 2026, at 2:08 PM, with the Director of Nursing (DON), the DON stated every resident who had a urinary catheter was supposed to have a dignity bag covering the urinary collection bag to maintain the resident's dignity and respect.A copy of the facility policy and procedure regarding using dignity bags to cover urinary collection bags was requested but not provided by the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for one of one resident (Resident 52) when Resident 52, who had a known history of verbal aggressive behaviors, was observed to be verbally abusing Resident 56 on May 7, 2026. This failure had the potential to place Resident 56 at risk for physical injury, fear, emotional distress, and psychosocial harm.Findings:A review of Resident 52's admission Record (contains medical and demographic information), indicated Resident 52 was admitted on [DATE], with diagnoses which included cerebral infarction (a serious medical emergency occurring when blood flow to a brain region is blocked, causing oxygen deprivation and tissue death), type 2 diabetes (a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar), and muscle weakness (a reduction in the strength of voluntary muscle contractions). A review of Resident 56's admission Record (contains medical and demographic information), indicated Resident 56 was admitted on [DATE], with diagnoses which included encephalopathy (a broad term for any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), type 2 diabetes (a chronic condition where the body cannot properly use or make enough insulin, leading to high blood sugar), and acute respiratory failure with hypoxia (a life-threatening emergency where the lungs cannot adequately transfer oxygen to the blood). During a review of the Resident 52 Care Plan, dated October 31, 2025, it indicated, Resident 52 is/has potential to be verbally aggressive with staff r/t Poor impulse control with selective staff. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness and Provide positive feedback for good behavior. Emphasize the positive aspects of compliance During an observation on May 7, 2026, at 11:59 AM in the facility's 300-Hall unit, Resident 52 was observed verbally abusing Resident 56 while both residents were lying in their beds in the same room. Resident 52 called Resident 56 asshole and a liar, and to turn his TV down. A Certified Nursing Assistant 1 (CNA 1) intervened. CNA 1 approached the residents in their room and asked Resident 52 the reason for verbally abusing Resident 56. Resident 52 continued yelling profanities at Resident 56 stating, fuck you, stop talking shit, put your fucking headphones on. You're being a smartass. During an interview with CNA 1 on May 7, 2026, at 12:10 PM, CNA 1 stated staff were aware of Resident 52's verbal aggression and stated, We try to keep a close eye on him when we can and also provide positive feedback for good behavior. During an interview on May 7, 2026, at 1:30 PM, with the Administrator (Admin) about the verbal abuse from Resident 52 to Resident 56. The admin stated the facility's expectation was to provide supervision and interventions necessary to protect residents from abuse, including resident-to-resident altercations. The administrator stated the interventions were not done. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated December 2016, with the Director of Nurses (DON) and the admin, in the administrator's office, the P&P indicated, .1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individuals. The admin stated the policy was not followed and should have been. The DON stated she agreed with the administrator.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Minimum Data Set (MDS - a computerized clinical assessment) Significant Change in Status Assessment (SCSA) within 14 days for one of five residents (Resident 53), who were reviewed for accidents when Resident 53 experienced a fall with a fracture on April 9, 2026.This failure had the potential to delay identification and implementation of necessary interventions to address the residents' care and support needs.Findings: During a review of Resident 53's admission Record (contains medical and demographic information), the admission Record, indicated Resident 53 was admitted to the facility on [DATE], with diagnosis which included history of falling, presence of left artificial hip joint, muscle weakness, and difficulty in walking.During a concurrent observation and interview on May 4, 2026, at 11:54 AM, with Resident 53, Resident 53 was lying in bed and stated she fell a while ago and thought it may have been a few weeks ago. Resident 53 further stated she fell in her restroom while she was by herself and broke her right arm. Resident 53 had her right arm wrapped with a compression type of bandage from her lower forearm to her fingers.During a review of Resident 53's Electronic Health Record (EHR - electronic medical record), the most recent MDS assessment was dated April 8, 2026 (dated one day prior to Resident 53's fall) and was a quarterly assessment (an abbreviated [shortened] version of a comprehensive MDS assessment). The MDS assessment section GG (section for functional abilities) GG0115 was coded no impairment for upper extremities (shoulder, elbow, wrist, hand). Further review of the quarterly MDS assessment dated [DATE], indicated section J1800 (section for falls) NO for the question has the resident had any falls since admission/entry or reentry or the prior assessment.During a review of Resident 53's nurse's progress notes, a note dated April 9, 2026, indicated .received report from bedside nurse regarding resident fall at 0702 AM [7:02 AM], upon assessment, resident was found kneeling down position on the bathroom. Resident report it was due to black out. She is currently alert and oriented x 3 and complaining pain to right wrist and states she hit her head on the wall. A bump is noted on the right temple.MD made aware and give order to send out patient to ER [emergency room] for further evaluationDuring further review of Resident 53's progress notes, a progress note dated April 9, 2026, titled, Change in Condition, (CIC) for Falls dated April 9, 2026, indicated, .resident alert and oriented x 3. Resident complaining of pain on right wrist, and she states she hit her head on the wall, a bump is noted to right temple.MD made aware and order to send resident to hospital.During a review of Resident 53's progress notes, a progress note dated April 9, 2026, indicated, Patient returned from hospital at 8:05 PM from [name of local hospital].transport with 2 person transfer in gurney, d/t [due to] s/p [status post] fall and splint placed to right wrist r/t distal radius fracture with order to follow up with orthopedist.During a concurrent interview and record review on May 7, 2026, at 2:16 PM, with the Director of Nursing (DON), the DON reviewed Resident 53's EHR and stated a significant change MDS assessment should have been done after Resident 53's change of condition was determined and documented on April 9, 2026, (when the resident fell and sustained a fracture). The DON further stated the significant change MDS assessment should have been done as soon as possible, but it was not. The DON stated the individual who would have been responsible for doing the significant change assessment was the Minimum Data Set Nurse 1 (MDS 1).During an interview on May 7, 2026, at 2:33 PM, with MDS 1, MDS 1 stated she thought a significant change assessment only needed to be done if there were more than two areas of the MDS that would have declined or improved and did not think an MDS assessment needed to be done for Resident 53's fall with fracture. MDS 1 further stated the facility followed the current version of the RAI manual for their policy and procedure.During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised October 2023, the P&P indicated, A comprehensive assessment of each resident is completed at intervals designated by OBRA (Omnibus Budget Reconciliation Act of 1987 - a federal law that established federally mandated (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident assessments required to evaluate a resident's physical, psychological, and functional status for care planning and regulatory compliance purposes).1. OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes.5. The RAI User's Manual.provides detailed information on timing and submission of assessments.During a review of CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Resident Assessment Instrument 3.0 User's manual, dated October 2025, version 1.20.1, the manual indicated on page 2-24, .03. Significant Change in Status Assessment (SCSA).The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline.a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting, 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. the nursing home may take up to 14 days to determine whether the criteria are met.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately code the Resident Assessment Instrument-Minimum Data Set (RAI-MDS - a computerized resident assessment tool) for one of two residents (Resident 30) reviewed for behavior and emotional mood, when the Resident 30's RAI-MDS dated [DATE], did not indicate Resident 30 was experiencing hallucinations.This failure had the potential to result in unmet care needs for Resident 30 which can potentially jeopardize the residents' health and safety.Findings: During a review of Resident 30's admission Record (contains medical and demographic information), the admission Record, indicated Resident 30 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia - such as hallucinations or delusions - with mood disorder symptoms like depression), anxiety disorder (a condition in which feelings of fear, worry, or dread become excessive, persistent and hard to control to the point where they interfere with everyday life), delirium due to known psychological condition (a change in consciousness and thinking caused directly by another illness, medication, or underlying condition which can lead to confusion, trouble focusing, and may include hallucinations, mood swings, or sleep problems).During a concurrent observation and interview on May 4, 2026, at 12:21 PM, Resident 30 was sitting in a wheelchair near the edge of his bed watching TV. Resident 30 calmly stated an individual was currently in his room and was choking him, tripping him and talking to him. There was nobody present in Resident 30's room other than the surveyor and Resident 30 was not assigned a roommate. Resident 30 stated the individual was choking and tripping him during our conversation.During a review of Resident 30's RAI-MDS assessment dated [DATE], the RAI-MDS assessment indicated in section E - Behaviors.E0100 Potential indicators of psychosis - check all that apply A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) Z. None of the above. staff had checked none of the above for this section.During a review of Resident 30's physician's orders, an order dated August 26, 2024, indicated, document episodes of auditory hallucinations every shift.During a review of Resident 30's care plan (an individualized plan for the medical care of a resident), titled, Schizoaffective disorder m/b [manifested by] auditory hallucinations. dated August 8, 2024, the care plan indicated, .interventions.when hallucinations are apparent, assess hallucinations (auditory, olfactory, tactile), document episodes of auditory hallucinations.During a review of Resident 30's Medication Administration Record (MAR - a document used to record medication administration and other physician's orders), dated April 1, 2026, through April 30, 2026, the MAR indicated staff had documented Resident 30 had experienced 74 instances of auditory hallucinations in April of 2026. 13 instances of auditory hallucination were documented as having occurred within the 7 day look back period (the span of time during which any resident symptoms, behaviors, or care needs that occurred within this window are documented) from April 9, 2026, through April 15, 2026.During a concurrent interview and record review on May 7, 2026, at 2:24 PM, with the Director of Nursing (DON), Resident 30's MAR dated April 1, 2026, through April 30, 2026, was reviewed. The DON acknowledged the MAR indicated Resident 30 had 74 instances of hallucinations in April 2026, with 13 instances occurring within the 7 day lookback period of the MDS assessment dated [DATE]. Resident 30's RAI-MDS assessment dated [DATE], was then reviewed and the DON stated the MDS was completed incorrectly for section E-Behaviors, since it did not indicate the resident had been experiencing hallucinations. The DON further stated the facility followed the Resident Assessment Instrument manual for instructions on completing MDS assessments.During a concurrent interview and record review on May 7, 2026, at 2:40 PM, with the Social Services Designee (SSD), The SSD reviewed Resident 30's RAI-MDS assessment dated [DATE], and stated she was the individual who completed section E-Behaviors, and indicated Resident 30 did not have hallucinations. Resident 30's MAR dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	April 1, 2026, through April 30, 2026, was reviewed and the SSD stated she incorrectly coded Section E-Behaviors, on the MDS assessment because she did not look at the MAR when determining if the resident was experiencing hallucinations.During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised October 2023, the P&P indicated, .12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. 13.The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.During a review of CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Resident Assessment Instrument 3.0 User's manual, dated October 2025, version 1.20.1, the manual indicated on page E-1, Section E: Behavior. Intent: the items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs preferences or illness.Hallucination.the perception of the presence of something that is not actually there. It may be auditory, or visual or involve smells, tastes or touch. Steps for Assessment.1. Review the resident's medical record for the 7-day look-back period.Coding Instructions.Code based on behaviors and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis.Check E0100A, hallucinations: if hallucinations were present in the last 7 days .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for medication administration for 1 of 14 sampled residents (Resident 116) when Licensed Vocational Nurse 1 (LVN 1) did not to administer Cholecalciferol (a vitamin to treat Vitamin D deficiency) as ordered by the physician. This failure had the potential to result in ineffective treatment, and adverse health outcomes for Resident 116.Findings: During a review of Resident 116's admission Record (contains medical and demographic information), indicated Resident 116 was admitted on [DATE], with diagnoses which included vitamin D deficiency (a common condition where the body lacks sufficient vitamin D, essential for bone health, immune function, and muscle strength). During a review of Resident 116 physician's orders, dated April 27, 2026, the physician's orders indicated, give Cholecalciferol 2000 units by mouth daily, give 2 tablets of 1000 unit for supplement. During a medication pass observation on May 7, 2026, at 8:12 AM, LVN 1 prepared medications for Resident 116. During a further medication pass observation on May 7, 2026, at 8:12 AM, revealed LVN 1 did not administer Cholecalciferol as ordered by the physician to Resident 116. During an interview on May 7, 2026, at 9:42 AM with LVN 1, LVN 1 reviewed Resident 116 Medication Administration Record (MAR-a legal document used by healthcare professionals to document the administration of drugs to a patient in real-time). The MAR indicated Resident 116 was prescribed Cholecalciferol 2000 units by mouth daily, give 2 tablets of 1000 unit for supplement. LVN 1 acknowledged the medication had been omitted, stating, I missed that medication during the pass. During an interview on May 7, 2026, at 4:14 PM, with the Director of Nursing (DON) in the administrator's office, the DON stated her expectation was for licensed nurses to follow the physician orders and verify all scheduled medications were administered and documented accurately during each medication pass. The DON further stated it was important to ensure medications were administered and documented as ordered by the physician. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, dated April 2019, with the DON, in the administrator's office, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Further review of the facility's P&P, it indicated, 4.Medications are administered in accordance with prescriber orders, including any required time frame. The DON stated the policy was not followed and should have been.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff monitored the indwelling foley catheter (a thin, flexible tube inserted through an opening into the bladder allowing continuous urine drainage into an external collection bag) for one of three residents (Resident 115) reviewed for urinary catheters when the tubing for Resident 115's urinary collection bag (bag connected to a catheter by a tube and is used to collect urine) was observed to be touching the floor and documentation of observation and monitoring of Resident 115's catheter was not documented as being performed as ordered by the physician.This failure exposed Resident 115 to increased risk of urinary tract infection and the spread of microorganisms (cross contamination), from the floor to his indwelling foley catheter.Findings:During a review of Resident 115's admission Record, (contains medical and demographic information), the admission Record, indicated Resident 115 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (an infection usually caused by bacteria entering the urinary tract), sepsis (the body's harmful overreaction to an infection which can cause to organ dysfunction, tissue damage, and death if not treated promptly), and bacteremia (presence of bacteria in the bloodstream).During an observation on May 4, 2026, at 12:33 PM, while in the hallway, Resident 115's room door was open, Resident 115 was lying in bed and the resident's urinary collection bag was attached to the side of his bed and the tubing which led to the indwelling foley catheter, was touching the floor.During a concurrent observation and interview on May 4, 2026, at 12:36 PM, with Certified Nursing Assistant 4 (CNA 4), while in the hallway, CNA 4 stated she was unsure of how the positioning of Resident 115's foley catheter tubing was supposed to be. CNA 4 acknowledged the tubing was touching the floor.During a review of Resident 115's physician's orders, an order dated April 23, 2026, indicated, Foley catheter care: monitor for patency, placement and positioning every shift.During a review of Resident 115's Treatment Administration Record (TAR - document used by staff to record treatments administered to the resident), dated May 1, 2026, through May 31, 2026, the TAR had blanks next to two of fifteen (2 of 15) shifts for Foley Catheter Care: monitor for patency, placement, and positioning every shift.During a review of Resident 115's TAR, dated April 1, 2026, through April 30, 2026, the TAR had blanks next to three of 22 (3 of 22) shifts for foley catheter care: monitor for patency, placement, and positioning every shift.During an interview on May 6, 2026, at 2:36 PM, with the facility's Infection Preventionist (IP), the IP stated urinary catheter drainage bags were supposed to be always positioned below the bladder, and the tubing should be free of kinks, should not be coiled, and should not be touching the floor. The IP further stated it was important to ensure the tubing was not touching the floor because the floor was dirty and it could cause increased risk for infection.During an interview on May 7, 2026, at 2:08 PM, with the Director of Nursing (DON), the DON stated the tubing for foley catheter drainage bags should be placed appropriately which included ensuring the tubing was not kinked, the urinary collection bag was lower than the bladder, and the tubing was off the floor. The DON further stated it was important to keep the tubing off the floor for infection control.During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, Revised September 2014, the P&P indicated, The purpose of this procedure is to prevent catheter-associated urinary tract infections.Infection Control.b. Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that allows residents' to communicate with nursing staff when they need assistance) was within resident reach for one of five sampled residents (Resident 91) when Resident 91 call light was wedged/stuck between the mattress and the side bed rail and not accessible to Resident 91.This failure had the potential to place Resident 91 at risk for their safety and well-being.Finding:A review of Resident 91's admission Record, (contains demographic and medical information), indicated Resident 91 was admitted to the facility on [DATE], with diagnoses which included epilepsy (a brain disorder that causes repeated, unprovoked seizures), anxiety disorder (persistent, and uncontrollable fear or worry that interferes with daily life) and altered mental status (any sudden or significant change in a person's normal thinking, awareness, or behavior). During a concurrent observation and interview on May 4, 2026, at 11:22 AM, with Resident 91 in the room, observed Resident 91 lying in bed and repeatedly touching and rubbing her head. Resident 91stated she had a headache. When asked whether nursing staff had been notified, resident 91 stated she had not informed staff because she had not seen her nurse. Resident 91 further stated she did not know where her call light was located. An observation of resident call light, it was observed wedged between the mattress and the side bed rail and was not accessible to the resident. As a result, Resident 91 was unable to independently notify staff for assistance and to report pain and request care.During a concurrent observation and interview on May 4, 2026, at 11:27 AM, with Licensed Vocational Nurse 1 (LVN 1), in Resident 91's room, LVN 1 observed and verified Resident 91's call light wedged between the mattress and the side bed rail and not accessible to the resident. The LVN was observed attempting to pull the call light cord from between the mattress and bed frame, noting difficulty retrieving it. The LVN stated the call light should not be there and confirmed that the call light must remain accessible to the resident at all times. The LVN further stated it is important for the call light to be within reach so resident can request assistance when needed, such as now with residents compliant of a headache and request for pain medication. LVN further acknowledge Resident 91 was unable to use the call light to request assistance for resident's headache. During a concurrent interview and record review on May 5, 2026 at 4:23 PM with the Administrator (Admin) and the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Answering the Call Light dated March 2021 was reviewed. The P&P indicated, The purpose of this procedure is to ensure timely responses to the resident's request and needs.1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident.5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The DON stated the expectation is for call lights to remain within residents' reach at all times and acknowledged the facility's P&P was not followed. The Admin acknowledged the P&P was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055183	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Gardens Health Care Center	25271 Barton Rd Loma Linda, CA 92354

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post in a place readily accessible to residents, family members, and legal representatives of residents the results of the most recent survey of the facility. This failure had the potential to prevent residents, family members, and legal representatives from being informed about the facility's compliance with state and federal requirements, which could limit their ability to make fully informed decisions regarding the residents' care.Findings:During the Resident Council Meeting held on May 5, 2026, at 10:30 AM, residents expressed concerns regarding the visibility and accessibility of the most recent survey results of the facility. Further more, multiple residents reported that they were unaware of the location where these results were posted.During an interview with the Director of Nursing (DON) on May 5, 2026, at 11:15 AM, the DON acknowledged the most recent survey of the facility must be visibly posted in an unobstructed area and be accessible to the residents and the public. DON was unable to specify or demonstrate the location where the most recent survey of the facility was posted.During an interview with the facility's Administrator (ADMIN) on May 5, 2026, at 11:25 AM, the ADMIN stated that the most recent survey of the facility was usually posted by the bulletin board located in front of the nursing station. The ADMIN, the DON, and the surveyor proceeded to the specified location and upon inspection, the most recent survey of the facility was not found posted at the bulletin board. The ADMIN explained that a three-ring binder containing the results of the most recent survey was typically placed at this location and was unable to account for its absence at the time of inspection.During a concurrent interview and record review with the Admin on May 5, 2026, at 2:25 PM, the facility's policy and procedure (P&P) titled, Survey results, examination of revised April 2007 was reviewed. The P&P stated, 2. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plan of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.The ADMIN acknowledged that the facility's P&P were not properly followed, as the most recent survey results were not posted in a location that was easily accessible to residents, their family members, or legal representatives.